Moving Towards Health Equity

Health Equity

- Attainment of the highest level of health possible for all people.
- Achieving health equity requires valuing everyone with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health disparities and health care disparities

CDC

Health Inequity

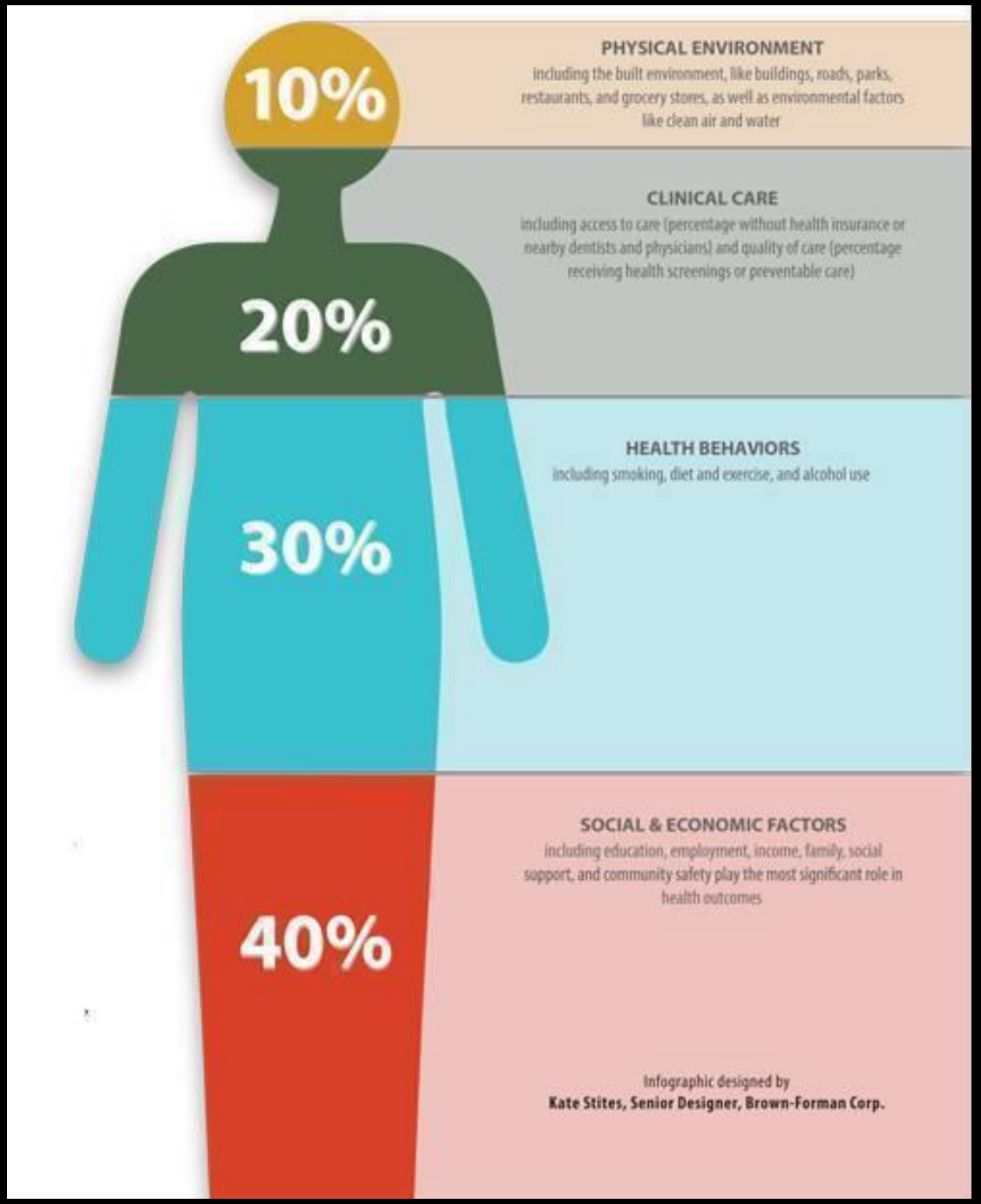
- Differences in health status between more and less socially and economically advantaged groups, caused by ***systematic*** differences in social conditions and processes that effectively determine health.
- Health inequities are ***avoidable***, ***unjust***, and therefore ***actionable***.

Mc Gearney et al Public Health. 2019;172:22-30.

Health Disparities and Health care Disparities

- Health Disparities
  - A difference in health status, health behavior, disability, morbidity, or mortality between socio-demographic groups
- Health care Disparities
  - Differences in quality of health care received that are not due to access-related factors or clinical needs, preferences, or appropriateness of intervention.

Factors that Determine Health



Factors that Determine Health

https://www.publichealthwm.org/what-health-equity/what-influences-health

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
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Table S.1. Ten Identified Approaches to Health Equity Measurement

Measurement Approach	Setting/Population	Social Risk Factor(s)	Focus
1. Measurement Framework for Evaluating How Well an Organization Meets National Standards for Culturally and Linguistically Appropriate Services (HHS OMH)	Health care organizations	Race/ethnicity; limited English proficiency; low literacy	Measure identification
2. NQF Disparities-Sensitive Measure Assessment	Cross-cutting	Race/ethnicity	Measure identification
3. AHRQ National Healthcare Quality and Disparities Report	Overall U.S. population	Age; sex, race/ethnicity	Measure-by-measure comparisons
4. CMS OMH Mapping Medicare Disparities Tool	Medicare FFS	Race/ethnicity; dual eligibility; sex; age	Measure-by-measure comparisons
5. CMS OMH Reporting of CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries	MA and prescription drug plans, Medicare FFS	Race/ethnicity	Measure-by-measure comparisons
6. Minnesota Healthcare Disparities Report	Minnesota health plan enrollees	Race, ethnicity, preferred language, country of origin	Measure-by-measure comparisons
7. CMS Assessment of Hospital Disparities for Dual-Eligible Patients	Hospitals	Dual eligibility	Measure-by-measure comparisons
8. CMS OMH Health Equity Summary Score	Medicare Advantage plans	Race/ethnicity; dual eligibility	Summary index
9. Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity	General adult U.S. population	Race/ethnicity; sex; income	Summary index
10. Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity	General adult U.S. population	Race/ethnicity; sex; income	Measure-by-measure comparisons; summary index

NOTE: CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; HHS = U.S. Department of Health and Human Services; FFS = fee-for-service; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; NQF = National Quality Forum; OMH = Office of Minority Health.

Set Of Guidelines For Health Equity Measurement

Be based on measures on which disparities in care are known to exist for certain populations or that address health care disparities and culturally appropriate care

Reflect available evidence on the relationship between a social risk factor and health or health care outcome

Be designed to incentivize achievement or improvement for at-risk beneficiaries, including having a valid and appropriate benchmark and/or reference group if comparisons to benchmarks and/or reference groups are made

Include design features that guard against unintended consequences of worsening quality or access or disincentivizing resources for any beneficiaries, including the at-risk beneficiaries who are the focus of health equity measurement

Establish measurability requirements that ensure the ability to make reliable distinctions between health care providers in their performance in the domain of health equity

Capture information about small subgroups where possible while limiting the influence of imprecise estimates of provider performance

Lown Institute Hospital Index

SOCIALLY RESPONSIBLE HOSPITALS PERFORM WELL ACROSS THREE AREAS:

HEALTH EQUITY

Which hospitals are the most inclusive in America, invest the most in community health, and pay their workers fairly?

HEALTH EQUITY RANKING

A

EQUITY

Reflects commitment to inclusivity, pay equity, and community investment

NATIONAL	479 of 3708
STATE	1 of 12

A

PAY EQUITY

Reflects how well hospital staff are paid compared to executives

NATIONAL	984 of 3699
STATE	1 of 12

INFO

A

COMMUNITY BENEFIT

Reflects how well hospitals invest in community health

NATIONAL	745 of 3641
STATE	3 of 12

INFO

B

INCLUSIVITY

Reflects how well hospitals serve people of color, people with lower incomes, and people with lower levels of education.

NATIONAL	2282 of 3548
STATE	5 of 11

INFO

Income ⓘ	★★★☆☆
Race ⓘ	★★★☆☆
Education ⓘ	★★☆☆☆

How do you obtain granularity?

First the basics

- REaL data — attributes of race, ethnicity, and language (REaL) tied to individual data records — used to stratify clinical, patient, and public health measures
- SO/GI data-Sexual Orientation and Gender Identity
- SDoH screening

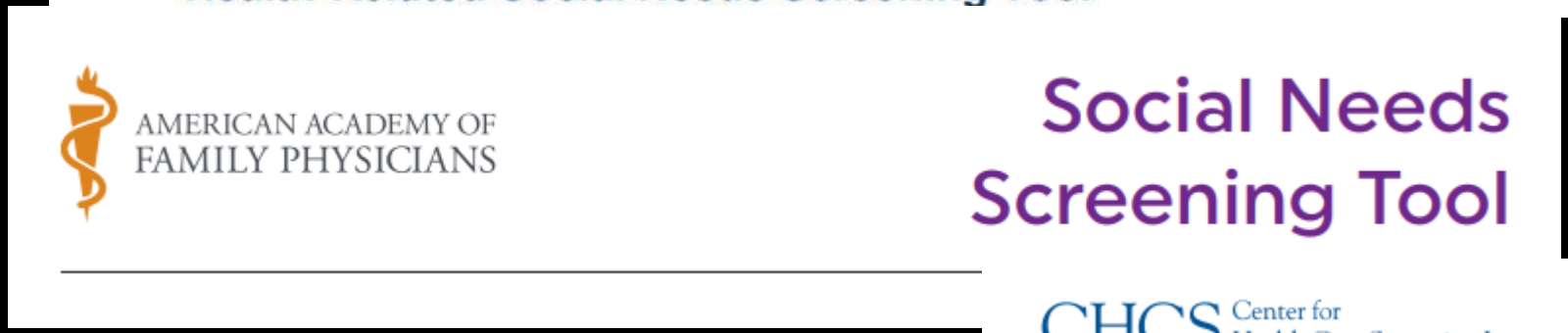
REaL Data

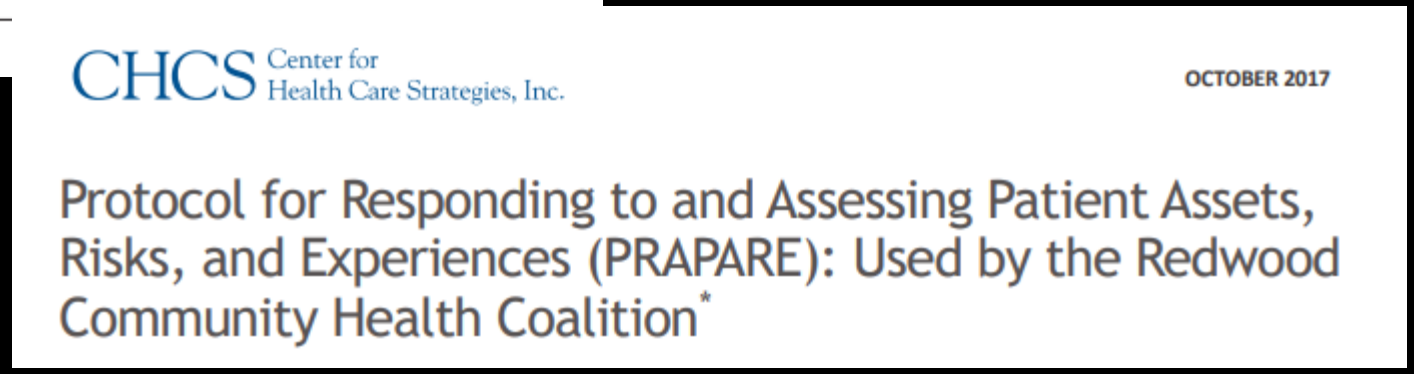
- Accuracy: Self-identified, correctly recorded, consistent categorization?
- Completeness: REaL data captured across all services? Percentage unknown, other, or declined tracked and evaluated?
- Uniqueness: Are individual patients represented only once?
- Timeliness: Are data updated regularly?
- Consistency: Are data internally consistent? Reflect the patient population served?

Ideally collect:

- Age
- Race and Ethnicity
  - Adding the type of granularity for Asian and Latino populations
- Primary language spoken
- Sexual Orientation
- Gender Identity
- Education
- Average household income
- insurance coverage

Tools Social Determinants of Health Screening





REaL Data and Social Determinants of Health Ask:

- Outpatient Hospital level SDoH screening with one socially cohesive state registry so you can have:
  - Benchmarking study deliverables
  - Provide current state and comparative analytics vs cohorts
  - Identify actionable opportunities based on data tool